Safety Plan Intervention to Reduce Suicide Risk Among Military Personnel and Veterans

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Overview

- Describe the Safety Plan Intervention, a method to manage suicidal crisis and promote recovery.
- Discuss the 6 steps that are used when creating the Safety Plan.
- Discuss implementation, especially those with TBI.
- Review preliminary findings with Veterans and describe project with Service Members.

Origin of Safety Planning Intervention (Stanley & Brown)

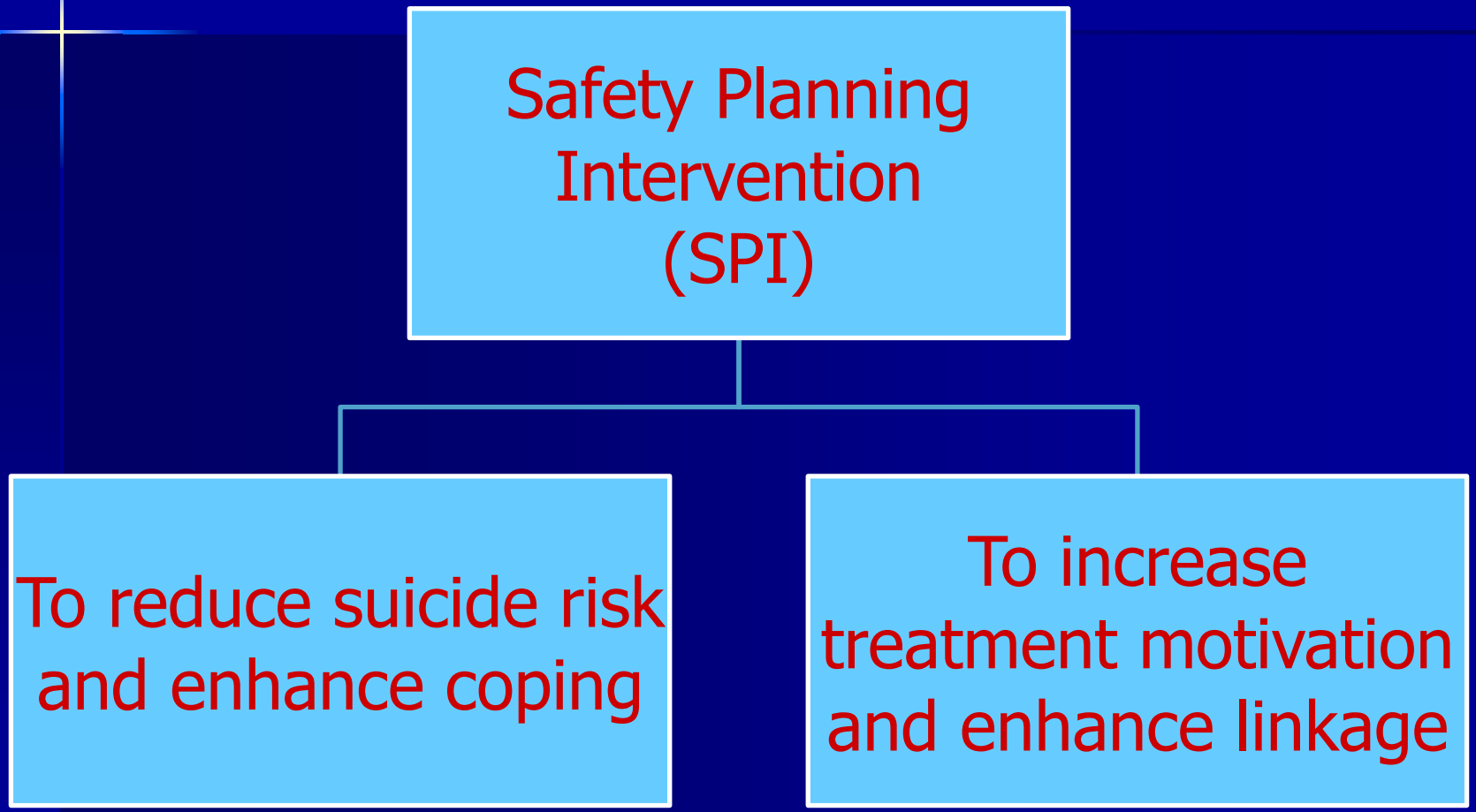
- To maintain safety of high risk patients in outpatient treatment trials (Penn CT study for adults; TASA study for suicidal adolescents)

- Expanded and modified as a stand alone intervention for the VA and in civilian EDs

'Theoretical' Approaches Underlying SPI

Three theoretical perspectives:

1. Suicide risk fluctuates over time (e.g., Diathesis-Stress Model of Suicidal Behavior, Mann et al., 1999)
2. Problem solving capacity diminishes during crises---over-practicing and a specific template enhances coping (e.g. Stop-Drop-Roll)
3. Cognitive behavioral approaches to behavior change (Emphasize on behavioral)
   - Behavioral strategies to identify individual stressors that have precipitated suicidal behavior in the past.
   - Therapist and patient collaborate to determine cognitive-behavioral strategies patient can use to manage suicidal crises.


Safety Planning Intervention (SPI)
To reduce suicide risk and enhance coping
To increase treatment motivation and enhance linkage

Reconcile the Difference Between…

Clinician's Goal:
Prevent suicide

Suicidal Individual's Goal:
Eliminate psychological pain via suicidal behavior

It is Critical to Communicate…

- that ending the individual's emotional pain is an important goal and is possible.
- that coping skills can be identified and used effectively.
- that preserving the patient's life is essential.
- support and encouragement that therapy will be helpful.

What is a Safety Plan?

- Prioritized written list of coping strategies and resources for use during a suicidal crisis
- Helps provide a sense of control
- Uses a brief, easy-to-read format that uses the patients' own words
- Encourages a commitment to coping (and staying alive)
- Provides a way to survive and actively counteract suicidal crisis; alternative to the 'white knuckle' approach

Safety Plan Intervention: What it is not? "No-Suicide Contract"

- No-suicide contracts ask people to promise to stay alive without telling them how to stay alive.
- No-suicide contracts may provide a false sense of assurance to the counselor and the institution.

Who Develops and Uses the Safety Plan Intervention?

- Collaboratively developed by the clinician and the suicidal individual in any clinical setting (sometimes not traditional 'clinical' settings).
- Veterans and Service Members (and others) who have…
  - made a suicide attempt.
  - suicide ideation.
  - psychiatric disorders that increase suicide risk.
  - otherwise been determined to be at high risk for suicide.

What do clinicians need to know before implementing the SPI?

- SPI is relatively easy to learn and easy to implement
- BUT……
- Clinicians have to remember this is NOT simply a form to complete; it's a collaborative intervention
- Clinicians need training---In person trainings, webinars, VA manual, DVDs, Stanley-Brown article in Cognitive and Behavioral Practice, practice by doing role plays.

When Is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process, e.g. 1st outpatient appt, the ED, prior to discharge from an inpatient unit, on crisis calls (hotlines) or other crisis situations.
- Usually follows a suicide risk assessment.
- Safety Plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
- The clinician should adapt the approach to the Veteran's or Service Member's needs -- such as involving family members in using the safety plan.

Beginning the Safety Plan: "Telling the Story"

- The Safety Plan starts with the individual's warning signs; the "story" helps to identify them.
- Have individuals describe the events and situations and their reactions to these events in as much detail as possible the led up to the suicidal crisis.
- Beginning of the story:
  - Major decision point associated with increased suicide risk
  - Strong emotional reaction to a specific event
    - External event such as a significant loss
    - Internal event such as an automatic thought
  - Follows backwards in time

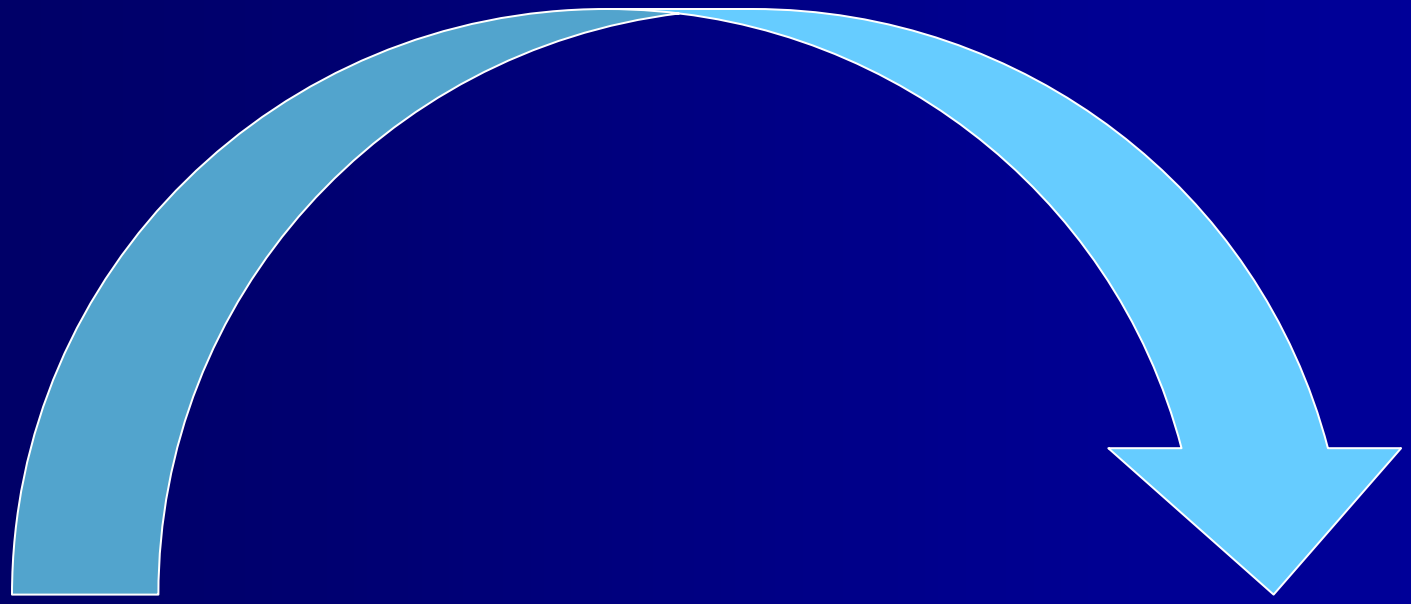
"Telling the Story"

1. Understand the function of suicidal behavior or thinking from the patient's perspective; that the behavior "makes sense" to the individual in the context of his or her history, vulnerability, and circumstances.
2. Empathize with the strong feelings and desire to be reduce distress.
3. Refrain from trying to solve the individual's problems before understanding the motivations for suicide.
4. Don't rush the interview!

Developing the Plan

- After the risk assessment is done and the patient describes the suicidal crisis, the SPI can be developed
- Solicit agreement to develop a plan
- Explain the rationale for such a plan and when to use the SPI

Suicide Risk Curve: SPI used to prevent risk from rising too high



Step 1: Recognizing Warning Signs

- Safety plan is only useful if the indiviudual can recognize the warning signs
- The clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis
- Say, “We have to figure out when the safety plan should be used.”

Step 1: Recognizing Warning Signs

- Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
- Write down the warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the individual's own words

Step 1: Recognizing Warning Signs Examples

- Automatic Thoughts
  - "I am a nobody."
  - "I am a failure."
  - "I don't make a difference."
  - "I am worthless."
  - "I can't cope with my problems."
  - "Things aren't going to get better."
- Images
  - "Flashbacks"

Step 1: Recognizing Warning Signs Examples

- Thinking Processes
  - “Having racing thoughts”
  - “Thinking about a whole bunch of problems”
- Mood
  - “Feeling depressed”
  - “Intense worry”
  - “Intense anger”

Step 1: Recognizing Warning Signs Examples

- Behavior
  - “Crying”
  - “Isolating myself”
  - “Using drugs”

Step 2: Using Internal Coping Strategies

- Identify activities that individuals can do without contacting another person
- Activities function as a way to help individuals take their minds off their problems and regulate their emotions
- Coping strategies prevent suicide ideation from escalating

Step 2: Using Internal Coping Strategies

- It is useful to have patients try to cope on their own with their suicidal feelings, even if it is just for a brief time

- Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"

Step 2: Using Internal Coping Strategies

- Examples:
  - Go for a walk
  - Listen to inspirational music
  - Take a hot shower
  - Walk the dog

Step 2: Using Internal Coping Strategies

- Ask "How likely do you think you would be able to do this step during a time of crisis?"
- Ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to address potential roadblocks

Step 3: Socializing with Family Members, Friends Others and Visiting Healthy Social Settings

- Coach patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Family, friends, or acquaintances who may offer support and distraction from the crisis.
- Social settings that provide support and distraction; that take people outside themselves

Step 3: Socializing with Family Members or Others

- Ask "Who do you enjoy socializing with?"
- Ask "Who helps you take your mind off your problems at least for a little while?"
- Ask individuals to list several people, in case they cannot reach the first person on the list
- Identify social settings that people can go to in order to be around others; this is helpful if they do not have a lot of people in their lives
- Settings should be healthy (not bars)

Step 4: Contacting Family Members or Friends for Help

- Coach individuals to use Step 4 if Step 3 does not resolve the crisis or lower risk
- Ask "How likely would you be willing to contact these individuals?"
- Identify potential obstacles and problem solve ways to overcome them
- Differs from prior step in that in this step, people identify that they are in distress

Step 5: Contacting Professionals and Agencies

- Coach individuals to use Step 5 if Step 4 does not resolve the crisis or lower risk
- Ask "Which professionals should be on your safety plan?"
- Identify potential obstacles and develop ways to overcome them

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
  - Clinicians
  - Local urgent care services
  - VA Suicide Prevention Coordinator (if VA patient)
  - Crisis Hotline
  - 800-273-TALK (8255), press "1" if Veteran or Service Member

Step 6: Reducing the Potential for Use of Lethal Means

- Ask individuals what means they would consider using during a suicidal crisis
- Regardless, the clinician should always ask whether there is access to a firearm; particularly problematic in the military

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with low lethality, clinicians may ask individuals to remove or restrict their access to these methods themselves
  - For example, if individuals are considering overdosing, discuss discarding any unnecessary medication

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with high lethality, collaboratively identify ways for a responsible person to secure or limit access
  - For example, if individuals are considering shooting themselves, suggest that they ask a trusted family member, friend or person in authority to store the gun in a secure place

Implementation: What is the Likelihood of Use?

1. Ask: "Where will you keep your safety plan?"

2. Ask: "How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?"

Implementation: What is the Likelihood of Use?

3. Ask: "What might get in the way or serve as a barrier to your using the safety plan?"
   - Help the individual find ways to overcome these barriers
   - May be adapted for brief crisis cards, cell phones or other portable electronic devices – must be readily accessible and easy-to-use

Implementation: Review the Safety Plan Periodically

- Periodically review, discuss, and possibly revise the safety plan after each time is it used
- The plan is not a static document
- It should be revised as circumstances and needs change over time

Safety Planning for those with Cognitive Impairment

poor memory, poor decision making, limited problem solving, lack of insight & impulsivity

Importance of **PACING & EXTERNAL SUPPORTS**:

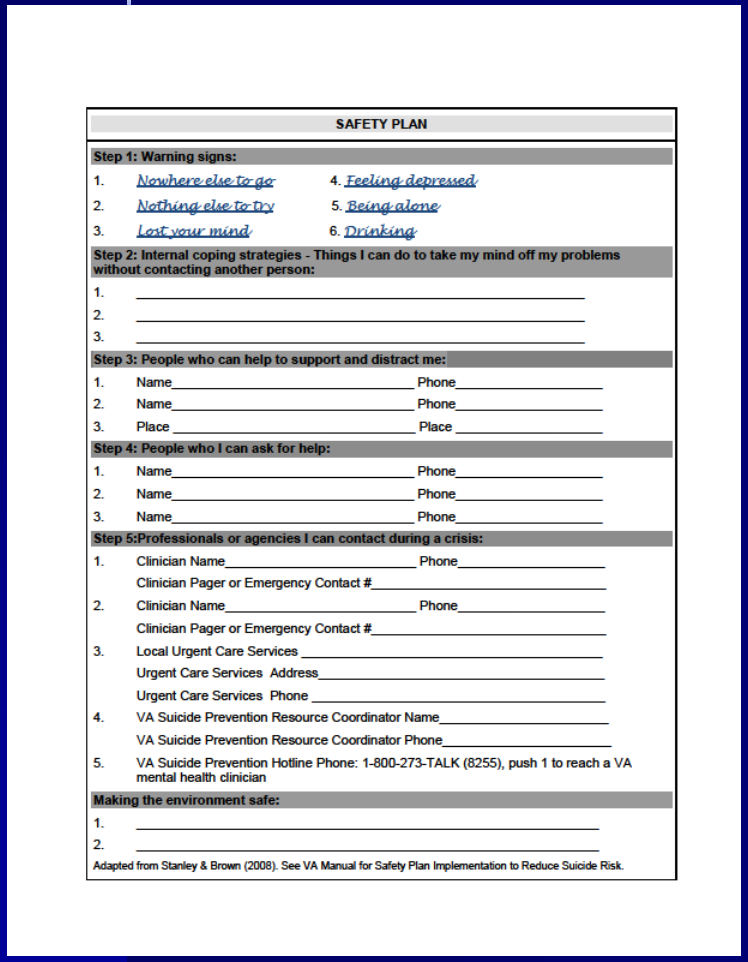
- Providing Safety Plan in multiple modalities
- Easily accessible/visible in Veteran's environment
- Including support persons whenever possible
- Practice
- Initiating plans to make sure steps are completed (don't assume that if you cover it in the session it is done)

Expect the process to take more time and plan for this

Prior to Crisis

- Review with Veteran, collateral contacts (support persons), and other providers
  - Medications that may be impacting cognitive functioning
  - Lethality of current medications being prescribed
    - How many are being sent/picked up at one time?
  - Impact of substance use/abuse on cognition

Step 1: Warning signs



SAFETY PLAN

Step 1: Warning signs:

1. *Nowhere else to go*
2. *Nothing else to try*
3. *Lost your mind*
4. *Feeling depressed*
5. *Being alone*
6. *Drinking*

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People who can help to support and distract me:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place _____ Place _____

Step 4: People who I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

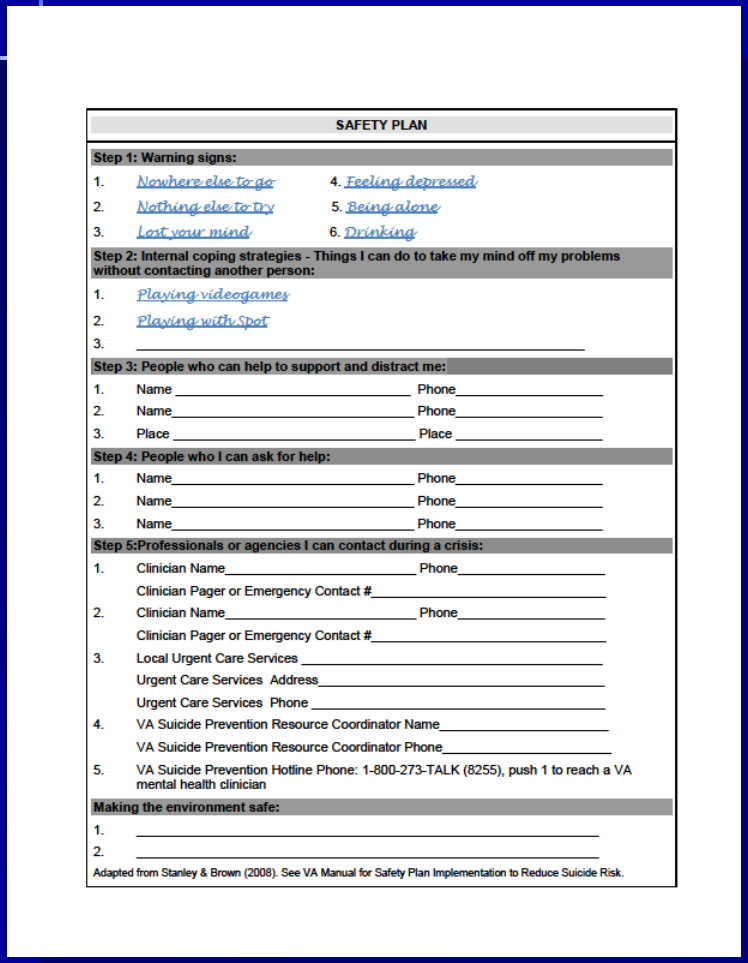
Making the environment safe:

1. _____
2. _____

Adapted from Stanley & Brown (2008). See VA Manual for Safety Plan Implementation to Reduce Suicide Risk.

- Lack of insight may negatively impact individual's ability to identify warning signs especially during a crisis
  - Concrete markers (e.g., depression)
- Consider including support person in this process
- Use language that is clear and concrete - preferably the Veteran's own

Step 2: Internal coping strategies



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1. Playing videogames
2. Playing with Spot
3. _____

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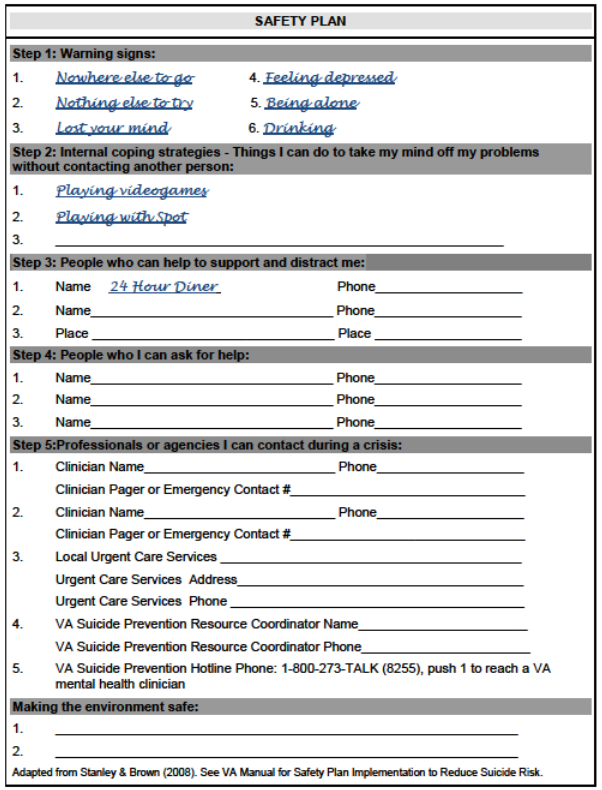
- Review steps necessary to engage in strategies (e.g., ensure that strategies are readily accessible and available)
  - Prepare ahead of crisis
- Use external supports (e.g., timer)
- Help Veteran identify markers of needing additional support and write this down

Step 3: People and social settings that provide distraction



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Step 3: People who can help to support and distract me:

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2. Name _____ Phone _____
3. Place _____ Place _____

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Making the environment safe:

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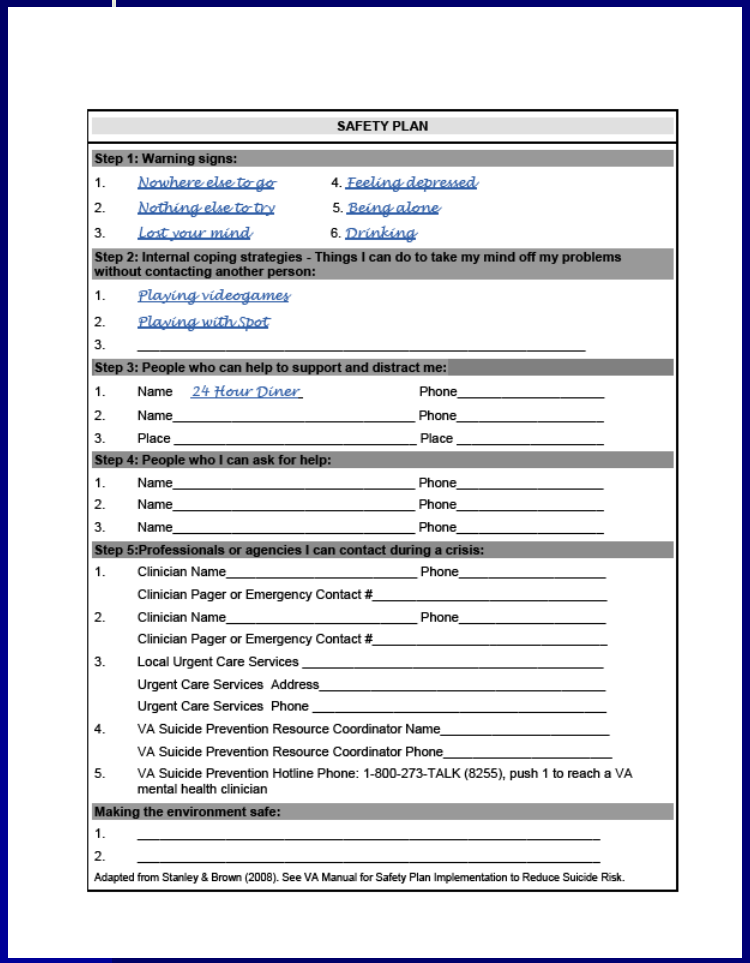
2. _____

Adapted from Stanley & Brown (2008). See VA Manual for Safety Plan Implementation to Reduce Suicide Risk.

- Mobility
- Transportation-related barriers
- Impulsivity in social settings (e.g., talking to strangers re: crisis)
  - Problem solve ahead of crisis

Step 4: People whom I can ask for help



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Making the environment safe:

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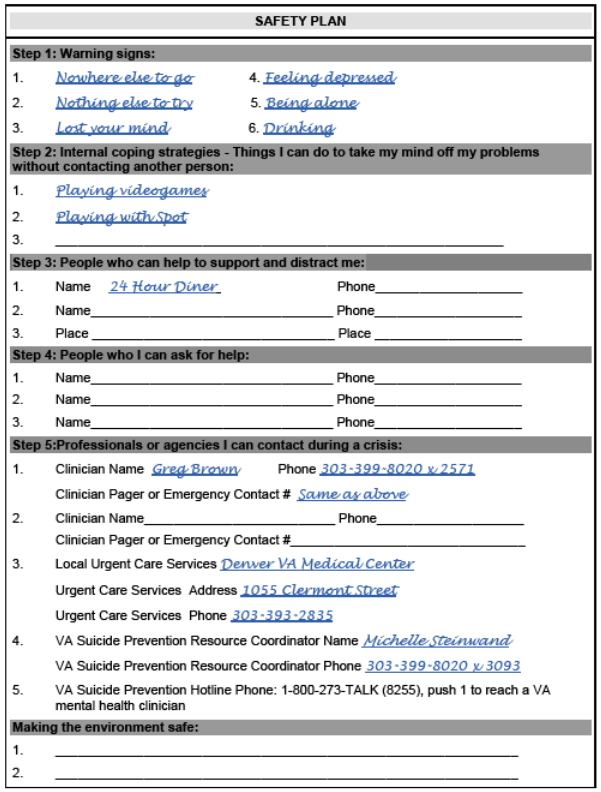
2. _____

Adapted from Stanley & Brown (2008). See VA Manual for Safety Plan Implementation to Reduce Suicide Risk.

- Social supports likely to be limited
  - Goal of treatment
- Plan ahead and set parameters for how much "help" each individual on list can provide – track how often each person is contacted and for how long
  - Caregiver burnout
- Create contact list (enter numbers in phone)
- Emphasize use of VA resources to augment (e.g., chat line, hotline)

Step 5: Professionals of agencies



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Step 5:Professionals or agencies I can contact during a crisis:

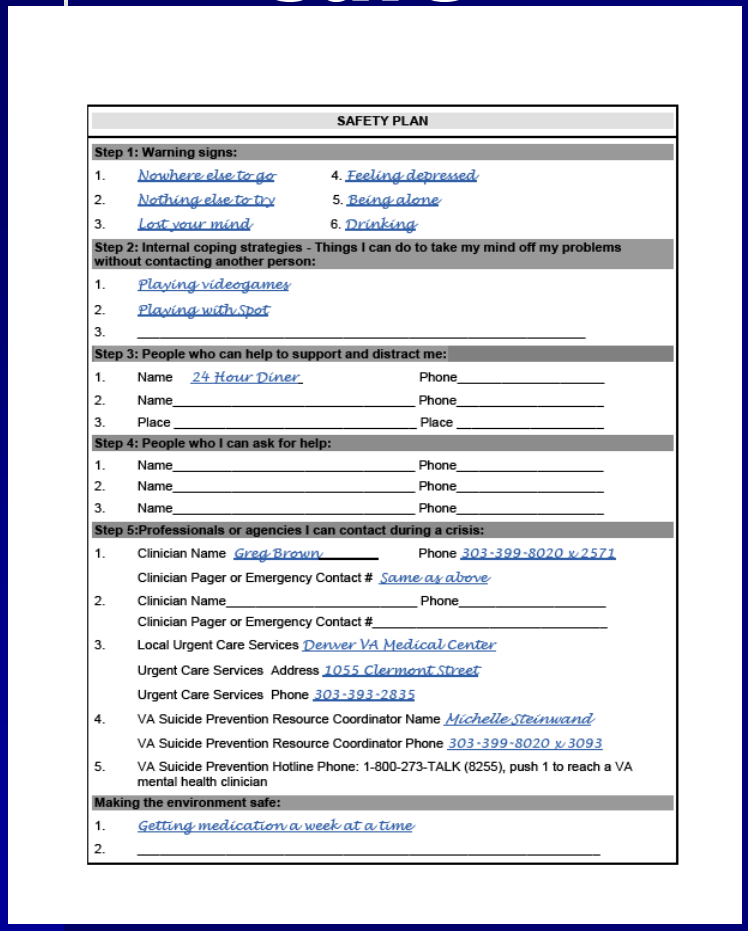
1. Clinician Name Greg Brown Phone 303-399-8020 x 2571
   Clinician Pager or Emergency Contact # Same as above
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services Denver VA Medical Center
   Urgent Care Services Address 1055 Clermont Street
   Urgent Care Services Phone 303-393-2835
4. VA Suicide Prevention Resource Coordinator Name Michelle Steinwand
   VA Suicide Prevention Resource Coordinator Phone 303-399-8020 x 3093
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Making the environment safe:

1. _____
2. _____

- Enter resources in phone
- Put contact information in other visible locations
  - Post numbers on phone, by computer, near medicine cabinet
- Provide support persons with professionals' #'s ahead of crisis

Step 6: Making the environment safe



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Making the environment safe:

1. Getting medication a week at a time
2. _____

- Don't assume that just because an individual has impairments they can't make a lethal attempt
- Include support persons
- Restrict means (e.g., scrips - lethality, # of pills, old meds -, gun locks)
- Provide concrete examples of reasons for living near means

Effectiveness of the Strategies used in SPI

- Treatment study using EMA
- Participants queried 6X/day before treatment about SI, coping strategies and effectiveness of strategies
- Four strategies reduced SI: Distracting activities; Socialization; Self-care/self-soothing; Focused on positive thoughts
- One strategy increased SI: ‘sitting with the feelings’

Qualitative Evaluation Preliminary Findings: Veterans

- Participant Demographics (N=100)
  - Average age: 45.13 $\pm$ 13.9
  - 91% Male
  - 42% Black; 40% White, 9% 2+ race, 3% Asian, 1% Hawaiian Native or Pacific Islander, 5% other
  - 77% Non-Hispanic

Qualitative Evaluation of SPI by Veterans: Acceptability

- When asked whether they remembered completing the safety plan in the ED:
  - 98 participants remembered receiving the Safety Planning Intervention without prompting.
- Most participants (*N*=87, 88%) still knew where their safety plan was.

Qualitative Evaluation of SPI by Veterans: Acceptability (cont'd)

- Sixty-one percent of Veteran participants (*n*=61) had used the safety plan.
  - Sixteen percent (*n*=10) used the safety plan daily; 66% (*n*=40) used it when they had a difficulty, and 16% (*n*=10) used it a few times.
  - Those who used the safety plan said it helped them recognize their warning signs (*n*=13, 21%), reminded them of their internal coping skills (*n*=16, 26%), and/or facilitated reaching out to supportive or helpful personal contacts (*n*=24, 39%) or professional resources (*n*=28, 46%).
- When asked to rate their overall satisfaction with the safety plan on a scale of 1-5, with 1 meaning 'very satisfied' and 5 meaning 'unsatisfied,' Veterans gave the intervention an average score of 1.34 (*sd*= 0.54).

Qualitative Evaluation of SPI by Veterans: Perceived Effectiveness

- When asked which aspects of the safety plan were most useful, 99 Veterans offered the following responses:
  - 82% (*n*=81) identified some component of the safety plan (e.g., identifying warning signs or contacts)
  - 12% (*n*=12) identified the structure of the Safety Plan (e.g., having a written list of prioritized crisis survival skills)
  - 12% (*n*=12) said feelings of self-efficacy provided by completing and using the Safety Plan
  - 12% (*n*=12) said contact with the ASC
- When asked if any aspect of the safety plan was unhelpful, 95% (n=95) of participants said no. The five participants that did find aspects of the safety plan unhelpful said it was too long, repetitive; it did not target his or her anger management issue; "the part about trying to think about something pleasant" was unhelpful, and "[it's] too hard to do things when really depressed."

Qualitative Evaluation of SPI by Veterans: Impact

- Impact/Effectiveness: SAFE VET
  - Most participants felt the safety plan and follow up calls were very helpful in making them feel connected to and cared for at the VA, though one individual felt the contact was a hassle.
    - *"It helped a lot, because it's not like I came here and got pushed aside. I see that they really must be concerned because [the ASC] still calls me."*
  - When asked whether they would recommend participating in a safety plan and receiving follow up calls to a friend in the same position, most Veterans said they would.
    - One offered, *"I would tell them it saved my life."*
  - The majority of participants felt the safety plan and follow up calls were very helpful in helping them attend follow-up appointments.
    - *"It helped me not to be such a tough guy and actually go for the help that I needed."*

Qualitative Evaluation of SPI by Veterans: Impact (cont'd)

- Most participants felt the safety plan and follow up calls were helpful in keeping them safe:
  - *"I think the program saved my life actually."*
  - *"I wasn't actually paying attention much in the past, but [my clinician] pointed in the right direction. I probably wouldn't be here right now, to tell you the truth."*

SPI for Service Members

To adapt and evaluate the **efficacy** of the *Safety Planning Intervention* for service members who are admitted for inpatient psychiatric treatment following a suicidal crisis.

Implementation Site: Walter Reed National Military Medical Center (WRNMMC)

SAFE-MIL Study Aims

1) To determine if SPI lowers suicide ideation
2) To determine if SPI increases suicide-related coping strategies
3) To determine if SPI increases the likelihood of attending mental health and substance-related treatment following discharge from WRNMMC

Sample Reactions at 1-Month Post Discharge

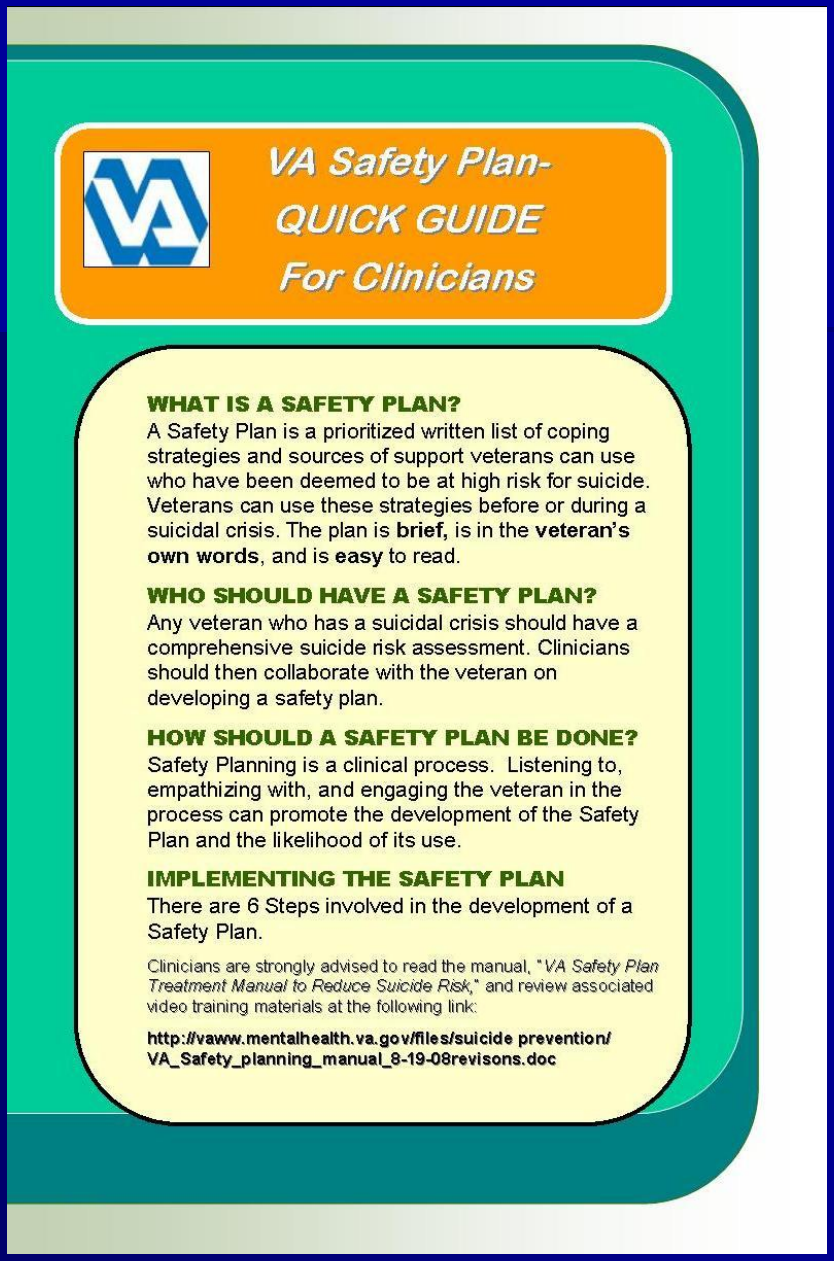
- **What was the most helpful part about having a safety plan?**
  - "Having a reminder that I do have people to help me and coping strategies to use. Gave me a sense of control."
  - "I remember items from plan after I wrote the plan out."
  - "The plan itself. Like military having guideline to go by."
  - "It's like knowing that the cruise line I'm on has lifeboats."
  - "Having it there since you can lose track of resources."
- **What would you suggest to others who are suicidal about safety planning?**
  - "It only works if you use it."
  - "I would recommend they do it. It's useful to know steps to prevent prior problems from getting too bad. Its helpful to show command to prove you have steps to deal with problems."

Resources

- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
- VA Safety Plan Form
- VA Safety Plan: Brief Instructions

  vaww.mentalhealth.va.gov

- VA Safety Plan: Pocket Card
- VA Safety Plan Template


VA Safety Plan-
QUICK GUIDE
For Clinicians
WHAT IS A SAFETY PLAN?
A Safety Plan is a prioritized written list of coping strategies and sources of support veterans can use who have been deemed to be at high risk for suicide. Veterans can use these strategies before or during a suicidal crisis. The plan is brief, is in the veteran's own words, and is easy to read.
WHO SHOULD HAVE A SAFETY PLAN?
Any veteran who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the veteran on developing a safety plan.
HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the veteran in the process can promote the development of the Safety Plan and the likelihood of its use.
IMPLEMENTING THE SAFETY PLAN
There are 6 Steps involved in the development of a Safety Plan.
Clinicians are strongly advised to read the manual, "VA Safety Plan Treatment Manual to Reduce Suicide Risk," and review associated video training materials at the following link:
http://vaww.mentalhealth.va.gov/files/suicide prevention/VA_Safety_planning_manual_8-19-08revisons.doc

Publications

Stanley, B., & Brown, G.K. (2011). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*, http://dx.doi.org/10.1016/j.cbpra.2011.01.001.